

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0046094</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Sunset Manor Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>129 South First Avenue</u> <u>Canton</u> <u>61520</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>Fulton</u>		(Signed) _____ (Date) _____																									
<b>Telephone Number:</b> <u>(309) 674-4327</u> <b>Fax #</b> <u>(309) 674-4354</u>		(Type or Print Name) _____																									
<b>IDPA ID Number:</b> <u>370997695001</u>		(Title) _____																									
<b>Date of Initial License for Current Owners:</b> <u>08/01/1990</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____																									
<b>Type of Ownership:</b> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<b>Paid Preparer</b> (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 634-3400</u> <b>Fax #</b> <u>(312) 634-5518</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
<b>IRS Exemption Code</b> _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630																									
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Christine Hanover</u> <b>Telephone Number:</b> <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page																											

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Sunset Manor Nursing Home# 0046094 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds12/19/2003

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>18</u>	Skilled (SNF)	<u>17</u>	<u>6,557</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>87</u>	Intermediate (ICF)	<u>90</u>	<u>31,794</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>105</u>	TOTALS	<u>107</u>	<u>38,351</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,367</u>	<u>1,367</u>	8
9	SNF/PED					9
10	ICF	<u>26,400</u>	<u>9,525</u>		<u>35,925</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,400</u>	<u>9,525</u>	<u>1,367</u>	<u>37,292</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 97.24%

D. How many bed-hold days during this year were paid by Public Aid?

164 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐ Non-allowable costs have been  
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/01/1990

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/01/1990 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 18 and days of care provided 1,367Medicare Intermediary AdminaStar Federal, Inc.

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Manor Nursing Home

Provider # 0046094

12/31/03

Schedule 2A

III. Statistical Data

A. Licensure/certification levels

BEDS:

	<u>352 days</u>	<u>13 days</u>
Skilled	18	17
Intermediate	87	90
	<u>105</u>	<u>107</u>

BED DAYS:

<u>352 days</u>	<u>13 days</u>	<u>Total</u>
6336	221	6557
30624	1170	31794
<u>36960</u>	<u>1391</u>	<u>38351</u>

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Sunset Manor Nursing Home # 0046094 Report Period Beginning: 01/01/03 Ending: 12/31/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	147,291	16,679		163,970		163,970	260	164,230			1
2	Food Purchase		162,006		162,006		162,006	(2,002)	160,004			2
3	Housekeeping	141,656	12,463		154,119		154,119		154,119			3
4	Laundry	48,668	18,549		67,217		67,217		67,217			4
5	Heat and Other Utilities			73,456	73,456		73,456	706	74,162			5
6	Maintenance	28,775	40,153	27,820	96,748		96,748	3,003	99,751			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	366,390	249,850	101,276	717,516		717,516	1,967	719,483			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			7,540	7,540		7,540		7,540			9
10	Nursing and Medical Records	1,349,948	57,741	14,378	1,422,067		1,422,067		1,422,067			10
10a	Therapy	117,415		5,055	122,470		122,470		122,470			10a
11	Activities	41,725	533		42,258		42,258		42,258			11
12	Social Services	23,370			23,370		23,370		23,370			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,532,458	58,274	26,973	1,617,705		1,617,705		1,617,705			16
	<b>C. General Administration</b>											
17	Administrative	102,892		114,310	217,202		217,202	(114,310)	102,892			17
18	Directors Fees											18
19	Professional Services			31,234	31,234		31,234	3,328	34,562			19
20	Dues, Fees, Subscriptions & Promotions			5,514	5,514		5,514	(10)	5,504			20
21	Clerical & General Office Expenses	50,458	5,999	17,172	73,629		73,629	19,068	92,697			21
22	Employee Benefits & Payroll Taxes			302,055	302,055		302,055	20,513	322,568			22
23	Inservice Training & Education			976	976		976	512	1,488			23
24	Travel and Seminar			570	570		570	1,745	2,315			24
25	Other Admin. Staff Transportation			5,765	5,765		5,765	1,640	7,405			25
26	Insurance-Prop.Liab.Malpractice			72,027	72,027		72,027	904	72,931			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	153,350	5,999	549,623	708,972		708,972	(66,610)	642,362			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,052,198	314,123	677,872	3,044,193		3,044,193	(64,643)	2,979,550			29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\* See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			134,719	134,719		134,719	29,763	164,482			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			183,087	183,087		183,087	10,343	193,430			32
33	Real Estate Taxes			56,163	56,163		56,163	(6,230)	49,933			33
34	Rent-Facility & Grounds							3,363	3,363			34
35	Rent-Equipment & Vehicles			2,496	2,496		2,496	659	3,155			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			376,465	376,465		376,465	37,898	414,363			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,181		25,181		25,181		25,181			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,488	57,488		57,488		57,488			42
43	Other (specify):* <b>Nonallowable Costs</b>			20,171	20,171		20,171	(20,171)				43
44	<b>TOTAL Special Cost Centers</b>		25,181	77,659	102,840		102,840	(20,171)	82,669			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,052,198	339,304	1,131,996	3,523,498		3,523,498	(46,916)	3,476,582			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**      A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
<b>NON-ALLOWABLE EXPENSES</b>				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms	(1,350)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	23,953	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(644)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(400)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(30)	43		24
25 Fund Raising, Advertising and Promotional	(6,542)	43		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(363)	43		28
29 Other-Attach Schedule See Schedule5A	(35,011)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,387)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(26,529)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (26,529)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (46,916)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Sunset Manor Nursing Home**  
**Provider # 0046094**  
**12/31/2003**

**Schedule 5A**

VI. Adjustment Detail  
Non-allowable Expenses - Line 29

Type	Amount	Reference
Offset meal income	(2,002)	2
Offset transportation income	(216)	25
Offset interest income	(1,658)	32
Offset telephone income	(463)	21
Offset cable TV income	(3,680)	43
Disallow Non-Allowable legal	(3,230)	19
Disallow settlement fees	(10,000)	19
Disallow Non-Allowable dues	(370)	20
Adjust RE tax to Medicaid calculation	(6,230)	33
Disallow Laboratory	(3,195)	43
Disallow Radiology	(525)	43
Disallow special events	(2,556)	43
Disallow Vendor Service Charges	(152)	43
Disallow Other	(734)	43
	<u>(35,011)</u>	

Sunset Manor Nursing Home

ID# 0046094

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

See Accountants' Compilation Report



## Summary A

12/31/03

12/31/03

[illegible]

## Summary B

12/31/03

[illegible]

Facility Name & ID Number Sunset Manor Nursing Home# 0046094

Report Period Beginning:

01/01/03

Ending:

12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100%	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$	Petersen Health Care Companies	0.00%	\$ 260	\$ 260 1
2	V	5 Utilities		Petersen Health Care Companies	0.00%	706	706 2
3	V	6 Maintenance supplies		Petersen Health Care Companies	0.00%	3,003	3,003 3
4	V	17 Administrative	114,310	Petersen Health Care Companies	0.00%		(114,310) 4
5	V	19 Professional services		Petersen Health Care Companies	0.00%	16,558	16,558 5
6	V	20 Dues, fees & subscriptions		Petersen Health Care Companies	0.00%	360	360 6
7	V	21 Clerical & general office		Petersen Health Care Companies	0.00%	19,531	19,531 7
8	V	22 Employee benefits		Petersen Health Care Companies	0.00%	20,513	20,513 8
9	V	23 Inservice training & education		Petersen Health Care Companies	0.00%	512	512 9
10	V	24 Travel & seminar		Petersen Health Care Companies	0.00%	1,745	1,745 10
11	V	25 Other admin. staff transport		Petersen Health Care Companies	0.00%	1,856	1,856 11
12	V	26 Insurance-property & liab.		Petersen Health Care Companies	0.00%	904	904 12
13	V	30 Depreciation		Petersen Health Care Companies	0.00%	5,810	5,810 13
14	Total		\$ 114,310			\$ 71,758	\$ * (42,552) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Manor Nursing Home# 0046094Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	32 Interest	\$	Petersen Health Care Companies	0.00%	\$ 12,001	\$ 12,001
16	V	34 Rent-facility & grounds		Petersen Health Care Companies	0.00%	3,363	3,363
17	V	35 Rent-equipment & vehicles		Petersen Health Care Companies	0.00%	659	659
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 16,023	\$ * 16,023

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Manor Nursing Home  
Provider # 0046094  
12/31/2003

**Schedule 6A**

**VII Related Parties - Page 6**

Note: All owned 100% by Mark Petersen.

Related Nursing Homes

City

In-State:

Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
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Related Assisted Living

Courtyard Estates	Kewanee, IL
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Other Related Business Entities

Petersen Health Care Companies	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Sunset Manor Nursing Home # 0046094 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	1.00	310,783	8	16.00	Salary	\$ 41,717	L17, C1	1
2											2
3											3
4					See Schedule 7A						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 41,717		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Manor Nursing Home  
Provider # 0046094  
12/31/2003

Schedule 7A

VII Related Parties

C Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Countryview Terrace	Eastview Terrace	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sullivan Health Care Center	Total Other Centers	Sunset Manor Nursing Home	TOTAL
Mark Petersen	37,699	23,276	6,197	22,462	32,710	28,962	25,443	34,589	35,181	26,725	28,388	9,151	310,783	41,717	352,500

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Manor Nursing Home# 0046094

Report Period Beginning:

01/01/03

Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Petersen Health Care Companies

Street Address

7218 N. Villa Lake

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309 ) 691-8113

Fax Number

( 309 ) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	315,110	13	\$ 2,200	\$	37,292	260	1
2	5	Utilities	Patient Days	315,110	13	5,963		37,292	706	2
3	6	Maintenance Supplies	Patient Days	315,110	13	25,373		37,292	3,003	3
4	19	Professional Services	Patient Days	315,110	13	139,914		37,292	16,558	4
5	20	Fees, Subscriptions, Promotions	Patient Days	315,110	13	3,044		37,292	360	5
6	21	Clerical & General Office	Patient Days	315,110	13	165,031		37,292	19,531	6
7	22	Employee Benefits	Patient Days	315,110	13	173,328		37,292	20,513	7
8	23	Inservice Training & Education	Patient Days	315,110	13	4,328		37,292	512	8
9	24	Travel & Seminar	Patient Days	315,110	13	14,743		37,292	1,745	9
10	25	Other Admin Staff Transport.	Patient Days	315,110	13	15,681		37,292	1,856	10
11	26	Insurance - Prop, Liab, Malpract	Patient Days	315,110	13	7,635		37,292	904	11
12	30	Depreciation	Patient Days	315,110	13	49,093		37,292	5,810	12
13	32	Interest	Patient Days	315,110	13	101,410		37,292	12,001	13
14	34	Rent-Facility & Grounds	Patient Days	315,110	13	28,419		37,292	3,363	14
15	35	Rent-Equipment & Vehicles	Patient Days	315,110	13	5,568		37,292	659	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 741,730	\$		\$ 87,781	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Sunset Manor Nursing Home # 0046094 Report Period Beginning: 01/01/03 Ending: 12/31/03

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle Bank		X	Mortgage	\$3,406.00	08/31/02	\$ 3,145,161	\$ 3,090,129	08/01/07	Varies	\$ 170,561	1	
2	Chrysler Financial		X	Vehicle Loan	\$529.00	04/30/02	19,039	7,973	11/10/04	Varies	2,155	2	
3	Bank of Farmington		X	Vehicle Loan	\$1,152.00	9/21/2001	55,280	24,185	01/2006	0.0725	400	3	
4												4	
5												5	
	Working Capital												
6	LaSalle Bank		X	Working Capital	Interest Only	08/31/02	275,050		08/31/03	Varies	9,971	6	
7												7	
8												8	
9	TOTAL Facility Related				\$5,087.00		\$ 3,494,530	\$ 3,122,287			\$ 183,087	9	
	B. Non-Facility Related*												
10								Home Office Allocation			12,001	10	
11								Offset Interest Income			(1,658)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 10,343	14	
15	TOTALS (line 9+line14)						\$ 3,494,530	\$ 3,122,287			\$ 193,430	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Sunset Manor Nursing Home**# **0046094**Report Period Beginning: **01/01/03**

Ending:

**12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																											
1. Real Estate Tax accrual used on 2002 report.		\$ <b>12,461</b>	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	\$ <b>31,194</b>	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>18,733</b>	3																								
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>31,200</b>	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>49,933</b>	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1998</td><td><b>10,903</b></td><td>8</td></tr> <tr><td>1999</td><td><b>12,083</b></td><td>9</td></tr> <tr><td>2000</td><td><b>12,660</b></td><td>10</td></tr> <tr><td>2001</td><td><b>12,461</b></td><td>11</td></tr> <tr><td>2002</td><td><b>31,194</b></td><td>12</td></tr> </table>	1998	<b>10,903</b>	8	1999	<b>12,083</b>	9	2000	<b>12,660</b>	10	2001	<b>12,461</b>	11	2002	<b>31,194</b>	12	<table border="1"> <tr><td colspan="2"><b>FOR OHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2002 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2002 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
1998	<b>10,903</b>	8																									
1999	<b>12,083</b>	9																									
2000	<b>12,660</b>	10																									
2001	<b>12,461</b>	11																									
2002	<b>31,194</b>	12																									
<b>FOR OHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2002 \$																										
14	PLUS APPEAL COST FROM LINE 5 \$																										
15	LESS REFUND FROM LINE 6 \$																										
16	AMOUNT TO USE FOR RATE CALCULATION \$																										
<b>Real estate accrual is 100% based on prior year's tax bill.</b>																											

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Sunset Manor Nursing Home COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0046094

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE ( 309 ) 691-8113 FAX #: ( 309 ) 691-8622

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-08-27-438-017</u>	<u>Jones 2nd Add 67,68.E 1/2 69.E 1/2</u>	\$ <u>31,193.94</u>	\$ <u>31,193.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>31,193.94</u>	\$ <u>31,193.94</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

See Accountants' Compilation Report

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,554
 B. General Construction Type:
 Exterior Brick
 Frame Steel
 Number of Stories Two

C. Does the Operating Entity?
 [X] (a) Own the Facility
 [ ] (b) Rent from a Related Organization.
 [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 [X] (a) Own the Equipment
 [X] (b) Rent equipment from a Related Organization.
 [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 [ ] YES
 [X] NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	Not Available	2002	\$ 95,000	1
2					2
3	TOTALS			\$ 95,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number    Sunset Manor Nursing Home

#    0046094

Report Period Beginning:

01/01/03

Ending:

12/31/03

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	105	2002	1972	\$ 2,315,000	\$ 59,359	30	\$ 77,167	\$ 17,808	\$ 115,750
5			2001	413,768	11,385	20	20,688	9,303	51,720
6	2		2003	148,271	1,237	20	3,707	2,470	3,707
7									
8									
<b>Improvement Type**</b>									
9	Petersen Properties Building Partnership		1990	6,417		15	428	428	5,671
10	Petersen Properties Building Partnership		1991	10,127		15	675	675	8,494
11	Petersen Properties Building Partnership		1993	4,719		15	315	315	3,176
12	Petersen Properties Building Partnership		1994	1,780		15	119	119	1,150
13	Petersen Properties Building Partnership		1995	13,199		20	660	660	5,766
14									
15	Field Audit		1990	1,102		15	73	73	989
16	Drapes		1995	8,206		20	410	410	3,417
17	Remodeling		1996	14,630	375	20	733	358	5,247
18	Awning		1996	1,105	49	20	55	6	390
19	Landscaping		1996	4,036	240	20	202	(38)	1,549
20	Back Taxes on Land		1996	531		20	26	26	156
21	Tiling		1997	500		20	25	25	150
22	Doors		1997	5,250	135	20	263	128	1,841
23	Tiling		1997	8,228	211	20	411	200	2,843
24	Gutters		1997	2,759	71	20	138	67	932
25	Landscaping		1997	1,886	113	20	94	(19)	635
26	Door Closer		1997	1,688	43	20	84	41	532
27	Concrete Slab		1997	1,440	37	20	72	35	480
28	Painting		1997	1,207	31	20	60	29	405
29	Furnace		1997	2,389	61	20	119	58	734
30	Awning		1997	4,077		20	204	204	1,326
31	Telephone System		1997	1,189	99	20	59	(40)	369
32	Roof/Windows		1998	36,145	927	20	1,807	880	9,939
33	Drapery		1998	1,402	36	20	70	34	385
34	Expansion Design		1998	3,639		20	182	182	1,001
35	Flooring/Cove Base		1998	619	16	20	31	15	171
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Awnings	1999	\$ 353	\$ 32	20	\$ 18	\$ (14)	\$ 81	37
38	Roof (Balance)	1999	1,000	26	20	50	24	225	38
39	Drapes	2000	1,966	50	20	98	48	343	39
40	Remove Trees	2000	1,072	27	20	54	27	189	40
41	Expansion	2000	1,945	50	20	98	48	343	41
42	Wood	2000	1,072	27	20	54	27	189	42
43	Land Work	2000	2,510	64	20	126	62	441	43
44	Flooring	2000	1,168	30	20	58	28	203	44
45	Shades	2001	1,788	46	20	89	43	223	45
46	Painting	2001	2,228	57	20	111	54	278	46
47	Carpet	2001	4,841	124	20	242	118	605	47
48	Carpet	2001	8,000	205	20	400	195	1,000	48
49	Painting	2001	345	9	20	17	8	43	49
50	Fire System	2001	42,286	1,084	20	2,114	1,030	5,285	50
51	Carpet	2001	2,155	55	20	108	53	270	51
52	Kitchen Remodeling	2001	43,315	581	20	2,166	1,585	5,415	52
53	Expansion	2002	7,352	14	20	368	354	554	53
54	Wall	2002	6,000	154	20	300	146	450	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,144,705	\$ 77,060		\$ 115,348	\$ 38,288	\$ 245,062	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

Facility Name &amp; ID Number Sunset Manor Nursing Home

# 0046094

Report Period Beginning:

01/01/03

Ending:

12/31/03

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 325,274	\$ 40,989	\$ 32,528	\$ (8,461)	10	\$ 142,936	71
72	Current Year Purchases	7,072	3,662	354	(3,308)	10	354	72
73	Fully Depreciated Assets	165,723					165,723	73
74								74
75	TOTALS	\$ 498,069	\$ 44,651	\$ 32,882	\$ (11,769)		\$ 309,013	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1990 Dodge Intrepid	1994	\$ 32,448	\$ 1,675		\$ (1,675)	4	\$ 32,448	76
77	Facility	1997 Ford E350 Van	1997	41,836				4	41,836	77
78	Facility	2001 Dodge Caravan	2001	47,863	6,433	11,966	5,533	4	29,915	78
79	Facility	2001 Chevy	2002	17,143	4,900	4,286	(614)	4	4,669	79
80	TOTALS			\$ 139,290	\$ 13,008	\$ 16,252	\$ 3,244		\$ 108,868	80

## E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,877,064	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,719	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,482	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,763	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 662,943	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		<u>Home Office Allocation</u>			<u>3,363</u>			5
6								6
7	TOTAL				\$ <u>3,363</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

N/A

N/A

N/A

9. Option to Buy:

☐

YES

☐

NO

Terms: N/A

\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☒ YES

☐ NO

16. Rental Amount for movable equipment: \$ 3,155

Description:

Oxygen Tanks - 829; Laundry equip - 199; Dietary equip - 1468; Home Office Allocation - 659

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			<u>N/A</u>		19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2004

\$

13. /2005

\$

14. /2006

\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT



A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	L10A,C1	1161 hrs	\$ 29,752		
2	Licensed Speech and Language Development Therapist	L10A,C1, C3	38 hrs	1,181	183	4,680			221	5,861	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10A,C1,C3	4427 hrs	86,482	10	375			4,437	86,857	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L39,C2	# of prescrpts					25,181		25,181	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$ 117,415	193	\$ 5,055	\$ 25,181	5,819	\$ 147,651	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

**Sunset Manor Nursing Home**

**Provider #: 0046094**

**01/01/03 to 12/31/03**

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

Service	Line Reference	Outside Practioner		Supplies
		Units	Cost	
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

**See Accountants' Compilation Report**

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Sunset Manor Nursing Home

# 0046094

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u> )	252,895	252,895	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,531	13,531	6
7	Other Prepaid Expenses	13,955	13,955	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Assessments</u>	14,583	14,583	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 294,964	\$ 294,964	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	165,630	95,000	13
14	Buildings, at Historical Cost	3,110,133	3,144,705	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	637,360	637,359	16
17	Accumulated Depreciation (book methods)	(661,708)	(662,943)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) <u>Unimproved Land</u>		70,630	22
23	Other(specify): <u>Goodwill</u>	1,790,000	1,790,000	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 5,041,415	\$ 5,074,751	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,336,379	\$ 5,369,715	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 228,853	\$ 228,853	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,825	89,825	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,200	31,200	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See attached schedule 17A</u>	367,015	367,015	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 716,893	\$ 716,893	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	32,158	32,158	39
40	Mortgage Payable	3,090,129	3,090,129	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 3,122,287	\$ 3,122,287	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,839,180	\$ 3,839,180	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,497,199	\$ 1,530,535	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 5,336,379	\$ 5,369,715	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Sunset Manor Nursing Home**  
**Provider # 0041996**  
**12/31/2002**

**Schedule 17A**

XV. Balance Sheet

Line 36: Other Current Liabilities

	Operating	After Consolidation
Imprest Fund	(750)	(750)
Imprest - bread fund	(300)	(300)
Cash in Bank - Gen	143,838	143,838
Due to Due from	14,359	14,359
Due to Patients	148,102	148,102
Accrued Vacation	43,263	43,263
Wage Garnishment	1	1
Accrued Sales Tax	143	143
Accrued Ins. - Gen	5,999	5,999
Accrued Expenses - Other	14,847	14,847
Accrued State Replacement Tax	(2,487)	(2,487)
Total	367,015	367,015

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 1,535,459</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior period adjustment</b>	<b>(9,916)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 1,525,543</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>43,068</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(71,412)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (28,344)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,497,199</b>	<b>24</b>

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Sunset Manor Nursing Home

# 0046094

Report Period Beginning: 01/01/03

Ending:

12/31/03

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,441,935	1
2	Discounts and Allowances for all Levels	6,948	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,448,883	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	92,000	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 92,000	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,002	14
15	Telephone, Television and Radio	4,143	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	231	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,376	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,658	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,658	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Attached schedule 19A</b>	17,649	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 17,649	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,566,566	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	717,516	31
32	Health Care	1,617,705	32
33	General Administration	708,972	33
<b>B. Capital Expense</b>			
34	Ownership	376,465	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	45,352	35
36	Provider Participation Fee	57,488	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,523,498	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	43,068	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 43,068	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
Entity is a cash basis taxpayer.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

**Sunset Manor Nursing Home**  
**Provider# 0046094**  
**12/31/03**

**Schedule 19A**

**E. Other Revenue - Line 28**

	<b>Amount</b>
<b>Transportation</b>	<b>216</b>
<b>Misc Income(Income Tax Refund)</b>	<b>17433</b>
	<b><u>17649</u></b>



Facility Name & ID Number **Sunset Manor Nursing Home**# **0046094**Report Period Beginning: **01/01/03**

Ending:

**12/31/03****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,777	1,777	\$ 40,244	\$ 22.65	1
2	Assistant Director of Nursing	1,967	2,007	43,197	21.52	2
3	Registered Nurses	9,704	10,122	227,341	22.46	3
4	Licensed Practical Nurses	18,495	21,742	334,435	15.38	4
5	Nurse Aides & Orderlies	72,023	71,313	666,615	9.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,626	5,626	117,415	20.87	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,836	1,836	12,998	7.08	9
10	Activity Assistants	3,895	3,927	28,727	7.32	10
11	Social Service Workers	2,080	2,080	23,370	11.24	11
12	Dietician					12
13	Food Service Supervisor	2,316	2,316	25,786	11.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,123	17,297	121,505	7.02	15
16	Dishwashers					16
17	Maintenance Workers	2,341	2,341	28,775	12.29	17
18	Housekeepers	17,634	18,512	141,656	7.65	18
19	Laundry	7,564	7,518	48,668	6.47	19
20	Administrator	1,993	1,993	61,175	30.69	20
21	Assistant Administrator					21
22	Other Administrative	246	246	41,717	169.58	22
23	Office Manager	1,807	1,807	27,319	15.12	23
24	Clerical	2,224	2,224	23,139	10.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Plan Coord.	2,438	2,438	38,116	15.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,089	177,122	\$ 2,052,198 *	\$ 11.59	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	7,540	L9,C3	36
37	Medical Records Consultant	monthly	203	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	576	C10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,319		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	152	\$ 6,384	L10,C3	50
51	Licensed Practical Nurses	234	7,215	L10,C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	386	\$ 13,599		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number    **Sunset Manor Nursing Home**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

#    **0046094**

Report Period Beginning:    **01/01/03**

Page 21

Ending:    **12/31/03**

<p><b>A. Administrative Salaries</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 10%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Cindy White</td> <td>Aministrator</td> <td>0%</td> <td style="text-align: right;">\$ 61,175</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td>Allocated from Home Office</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Mark Petersen</td> <td>Administrative</td> <td>100%</td> <td style="text-align: right;">41,717</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 102,892</td> </tr> </tbody> </table> <p><b>B. Administrative - Other</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Description</th> <th style="width: 30%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Management Fees (eliminated in column 7)</td> <td style="text-align: right;">\$ 114,310</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> <td style="text-align: right;">\$ 114,310</td> </tr> </tbody> </table> <p><b>C. Professional Services</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Vendor/Payee</th> <th style="width: 10%;">Type</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Altschuler, Melvoin, &amp; Glasser</td> <td>Accounting</td> <td style="text-align: right;">\$ 3,755</td> </tr> <tr> <td>AMEX Tax &amp; Business Services</td> <td>Accounting</td> <td style="text-align: right;">1,500</td> </tr> <tr> <td>Bush &amp; Snyder</td> <td>Legal</td> <td style="text-align: right;">969</td> </tr> <tr> <td>Kingery Durree Walkman &amp; Ryan</td> <td>Legal</td> <td style="text-align: right;">13,370</td> </tr> <tr> <td>Duane Morris</td> <td>Legal</td> <td style="text-align: right;">1,010</td> </tr> <tr> <td>ADP</td> <td>Payroll</td> <td style="text-align: right;">7,649</td> </tr> <tr> <td>America Online</td> <td>Computer Services</td> <td style="text-align: right;">200</td> </tr> <tr> <td>Ivans</td> <td>Computer Services</td> <td style="text-align: right;">601</td> </tr> <tr> <td>Rudy Hadsell</td> <td>Computer Services</td> <td style="text-align: right;">860</td> </tr> <tr> <td>LTC Solutions</td> <td>Computer Services</td> <td style="text-align: right;">1,320</td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)</td> <td> </td> <td style="text-align: right;">\$ 31,234</td> </tr> </tbody> </table>	Name	Function	Ownership %	Amount	Cindy White	Aministrator	0%	\$ 61,175													Allocated from Home Office				Mark Petersen	Administrative	100%	41,717									TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,892	Description	Amount	Management Fees (eliminated in column 7)	\$ 114,310							TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 114,310	Vendor/Payee	Type	Amount	Altschuler, Melvoin, & Glasser	Accounting	\$ 3,755	AMEX Tax & Business Services	Accounting	1,500	Bush & Snyder	Legal	969	Kingery Durree Walkman & Ryan	Legal	13,370	Duane Morris	Legal	1,010	ADP	Payroll	7,649	America Online	Computer Services	200	Ivans	Computer Services	601	Rudy Hadsell	Computer Services	860	LTC Solutions	Computer Services	1,320							TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 31,234	<p><b>D. 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\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Sunset Manor Nursing Home**  
**Provider #: 0046094**  
**01/01/03 to 12/31/03**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Total (agree to Schedule V, line 19, column 3)</b>	<b>31,234</b>
<b>Allocated from Management Company</b>	
<b>Other Professional Fees</b>	<b>14,283</b>
<b>Legal</b>	<b>2,275</b>
<b>Disallowed expenses</b>	<b>(13,230)</b>
<b>Total (agree to Schedule V, line 19, column 8)</b>	<b><u>34,562</u></b>

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7							N/A						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Sunset Manor Nursing Home

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,261 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 57,488  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,002
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 216
- c. What percent of all travel expense relates to transportation of nurses and patients? 10%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service: performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

## RECONCILIATION REPORT

Sunset Manor Nursing H

01:26 PM

11/4/2005

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-46,916	equal to	-46,916	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	193,430	equal to	193,430	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	49,933	equal to	49,933	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	164,482	equal to	164,482	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	3,363	equal to	3,363	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,155	equal to	3,155	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages	117,415	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	122,470	equal to	122,470	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	25,181	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	717,516	equal to	717,516	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,617,705	equal to	1,617,705	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	708,972	equal to	708,972	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	376,465	equal to	376,465	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	45,352	equal to	45,352	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	57,488	equal to	57,488	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,349,948	equal to	1,349,948	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	117,415	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	41,725	equal to	41,725	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	23,370	equal to	23,370	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	147,291	equal to	147,291	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	28,775	equal to	28,775	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	141,656	equal to	141,656	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	48,668	equal to	48,668	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	102,892	equal to	102,892	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	50,458	equal to	50,458	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,052,198	equal to	2,052,198	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	0	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,540	< or = to	7,540	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	14,378	< or = to	14,378	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	102,892	equal to	102,892	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	114,310	equal to	114,310	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	31,234	equal to	31,234	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	322,568	equal to	322,568	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,504	equal to	5,504	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,315	equal to	2,315	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	57,488	equal to	57,488	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	20,513	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,367	equal to	1,367	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-26,529	equal to	-26,529	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	3,122,287	equal to	3,122,287	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	31,200	equal to	31,200	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	95,000	equal to	95,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,144,705	equal to	3,144,705	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	637,359	equal to	637,359	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	662,943	equal to	662,943	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,497,199	equal to	1,497,199	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	43,068	equal to	43,068	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	5,336,379	equal to	5,336,379	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

[illegible][illegible][illegible][illegible][illegible]

Lateral inhibition: Modulators		
Rank	General	General demonstrations
	Rank	Rank
262	1 1182	1182
263	1 1178	1178
264	1 1271	11270
265	1 1270	11270
266	1 1362	11362
267	1 1361	11361
268	1 1371	11370
269	1 1370	11370
270	1 1487	11148
271	1 1486	11148
272	1 1512	11151
273	1 1511	11151
274	1 1510	11150
275	1 1509	11150
276	1 1508	11150
277	1 1507	11150
278	1 1506	11150
279	1 1505	11150
280	1 1504	11150
281	1 1503	11150
282	1 1502	11150
283	1 1501	11150
284	1 1499	11150
285	1 1498	11150
286	1 1497	11150
287	1 1496	11150
288	1 1495	11150
289	1 1494	11150
290	1 1493	11150
291	1 1492	11150
292	1 1491	11150
293	1 1490	11150
294	1 1489	11150
295	1 1488	11150
296	1 1487	11150
297	1 1486	11150
298	1 1485	11150
299	1 1484	11150
300	1 1483	11150
301	1 1482	11150
302	1 1481	11150
303	1 1480	11150
304	1 1479	11150
305	1 1478	11150
306	1 1477	11150
307	1 1476	11150
308	1 1475	11150
309	1 1474	11150
310	1 1473	11150
311	1 1472	11150
312	1 1471	11150
313	1 1470	11150
314	1 1469	11150
315	1 1468	11150
316	1 1467	11150
317	1 1466	11150
318	1 1465	11150
319	1 1464	11150
320	1 1463	11150
321	1 1462	11150
322	1 1461	11150
323	1 1460	11150
324	1 1459	11150
325	1 1458	11150
326	1 1457	11150
327	1 1456	11150
328	1 1455	11150
329	1 1454	11150
330	1 1453	11150
331	1 1452	11150
332	1 1451	11150
333	1 1450	11150
334	1 1449	11150
335	1 1448	11150
336	1 1447	11150
337	1 1446	11150
338	1 1445	11150
339	1 1444	11150
340	1 1443	11150
341	1 1442	11150
342	1 1441	11150
343	1 1440	11150
344	1 1439	11150
345	1 1438	11150
346	1 1437	11150
347	1 1436	11150
348	1 1435	11150
349	1 1434	11150
350	1 1433	11150
351	1 1432	11150
352	1 1431	11150
353	1 1430	11150
354	1 1429	11150
355	1 1428	11150
356	1 1427	11150
357	1 1426	11150
358	1 1425	11150
359	1 1424	11150
360	1 1423	11150
361	1 1422	11150
362	1 1421	11150
363	1 1420	11150
364	1 1419	11150
365	1 1418	11150
366	1 1417	11150
367	1 1416	11150
368	1 1415	11150
369	1 1414	11150
370	1 1413	11150
371	1 1412	11150
372	1 1411	11150
373	1 1410	11150
374	1 1409	11150
375	1 1408	11150
376	1 1407	11150
377	1 1406	11150
378	1 1405	11150
379	1 1404	11150
380	1 1403	11150
381	1 1402	11150
382	1 1401	11150
383	1 1400	11150
384	1 1399	11150
385	1 1398	11150
386	1 1397	11150
387	1 1396	11150
388	1 1395	11150
389	1 1394	11150
390	1 1393	11150
391	1 1392	11150
392	1 1391	11150
393	1 1390	11150
394	1 1389	11150
395	1 1388	11150
396	1 1387	11150
397	1 1386	11150
398	1 1385	11150
399	1 1384	11150
400	1 1383	11150
401	1 1382	11150
402	1 1381	11150
403	1 1380	11150
404	1 1379	11150
405	1 1378	11150
406	1 1377	11150
407	1 1376	11150
408	1 1375	11150
409	1 1374	11150
410	1 1373	11150
411	1 1372	11150
412	1 1371	11150
413	1 1370	11150
414	1 1369	11150
415	1 1368	11150
416	1 1367	11150
417	1 1366	11150
418	1 1365	11150
419	1 1364	11150
420	1 1363	11150
421	1 1362	11150
422	1 1361	11150
423	1 1360	11150
424	1 1359	11150
425	1 1358	11150
426	1 1357	11150
427	1 1356	11150
428	1 1355	11150
429	1 1354	11150
430	1 1353	11150
431	1 1352	11150
432	1 1351	11150
433	1 1350	11150
434	1 1349	11150
435	1 1348	11150
436	1 1347	11150
437	1 1346	11150
438	1 1345	11150
439	1 1344	11150
440	1 1343	11150
441	1 1342	11150
442	1 1341	11150
443	1 1340	11150
444	1 1339	11150
445	1 1338	11150
446	1 1337	11150
447	1 1336	11150
448	1 1335	11150
449	1 1334	11150
450	1 1333	11150
451	1 1332	11150
452	1 1331	11150
453	1 1330	11150
454	1 1329	11150
455	1 1328	11150
456	1 1327	11150
457	1 1326	11150
458	1 1325	11150
459	1 1324	11150
460	1 1323	11150
461	1 1322	11150
462	1 1321	11150
463	1 1320	11150
464	1 1319	11150
465	1 1318	11150
466	1 1317	11150
467	1 1316	11150
468	1 1315	11150
469	1 1314	11150
470	1 1313	11150
471	1 1312	11150
472	1 1311	11150
473	1 1310	11150
474	1 1309	11150
475	1 1308	11150
476	1 1307	11150
477	1 1306	11150
478	1 1305	11150
479	1 1304	11150
480	1 1303	11150
481	1 1302	11150
482	1 1301	11150
483	1 1300	11150
484	1 1299	11150
485	1 1298	11150
486	1 1297	11150
487	1 1296	11150
488	1 1295	11150
489	1 1294	11150
490	1 1293	11150
491	1 1292	11150
492	1 1291	11150
493	1 1290	11150
494	1 1289	11150
495	1 1288	11150
496	1 1287	11150
497	1 1286	11150
498	1 1285	11150
499	1 1284	11150
500	1 1283	11150

Total:

2010s		Revised 2010s	
Percentage	Count	Percentage	Count
31.77	2,630	31.77	2,630
26.73	2,249	26.73	2,249
31.77	2,630	31.77	2,630
27.63	2,303	27.63	2,303
31.76	2,629	31.76	2,629
31.76	2,629	31.76	2,629
32.01	2,668	32.01	2,668
30.98	2,585	30.98	2,585

Table 1. The ICD-10 of Depression

2010s	Before 2010s
<u>Percentage</u>	<u>Per Capita</u>
27.19	3.880
26.67	3.710
26.64	3.690
26.67	3.710
23.78	3.400
31.64	4.930
31.64	4.930
31.64	4.930
29.32	4.190
27.19	3.880
30.63	3.430





	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	147,291	16,679	0	163,970	0	163,970	260	164,230
2. Food Purchase	0	162,006	0	162,006	0	162,006	-2,002	160,004
3. Housekeeping	141,656	12,463	0	154,119	0	154,119	0	154,119
4. Laundry	48,668	18,549	0	67,217	0	67,217	0	67,217
5. Heat and Other Utilities	0	0	73,456	73,456	0	73,456	706	74,162
6. Maintenance	28,775	40,153	27,820	96,748	0	96,748	3,003	99,751
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	366,390	249,850	101,276	717,516	0	717,516	1,967	719,483
9. Medical Director	0	0	7,540	7,540	0	7,540	0	7,540
10. Nursing & Medical Records	1,349,948	57,741	14,378	1,422,067	0	1,422,067	0	1,422,067
10a. Therapy	117,415	0	5,055	122,470	0	122,470	0	122,470
11. Activities	41,725	533	0	42,258	0	42,258	0	42,258
12. Social Services	23,370	0	0	23,370	0	23,370	0	23,370
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,532,458	58,274	26,973	1,617,705	0	1,617,705	0	1,617,705
17. Administrative	102,892	0	114,310	217,202	0	217,202	-114,310	102,892
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	31,234	31,234	0	31,234	3,328	34,562
20. Fees, Subscriptions & Promotion	0	0	5,514	5,514	0	5,514	-10	5,504
21. Clerical & General Office	50,458	5,999	17,172	73,629	0	73,629	19,068	92,697
22. Employee Benefits & Payroll	0	0	302,055	302,055	0	302,055	20,513	322,568
23. Inservice Training & Education	0	0	976	976	0	976	512	1,488
24. Travel and Seminar	0	0	570	570	0	570	1,745	2,315
25. Other Admin. Staff Trans	0	0	5,765	5,765	0	5,765	1,640	7,405
26. Insurance-Prop.Liab.Malpractice	0	0	72,027	72,027	0	72,027	904	72,931
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	153,350	5,999	549,623	708,972	0	708,972	-66,610	642,362
29. Total General Administrative	2,052,198	314,123	677,872	3,044,193	0	3,044,193	-64,643	2,979,550
30. Depreciation	0	0	134,719	134,719	0	134,719	29,763	164,482
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	183,087	183,087	0	183,087	10,343	193,430
33. Real Estate	0	0	56,163	56,163	0	56,163	-6,230	49,933
34. Rent - Facility & Grounds	0	0	0	0	0	0	3,363	3,363
35. Rent - Equipment & Vehicles	0	0	2,496	2,496	0	2,496	659	3,155
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	376,465	376,465	0	376,465	37,898	414,363
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	25,181	0	25,181	0	25,181	0	25,181
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	57,488	57,488	0	57,488	0	57,488
43. Other (specify):*	0	0	20,171	20,171	0	20,171	-20,171	0
44. Total Special Cost Ce	0	25,181	77,659	102,840	0	102,840	-20,171	82,669
45. Grand Total	2,052,198	339,304	1,131,996	3,523,498	0	3,523,498	-46,916	3,476,582

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	252,895	252,895
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	13,531	13,531
7. Other Prepaid Expenses	13,955	13,955
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	14,583	14,583
10. Total current assets	294,964	294,964
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	165,630	95,000
14. Buildings, at Historical Cost	3,110,133	3,144,705
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	637,360	637,359
17. Accumulated Depreciation (book methods)	-661,708	-662,943
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	70,630
23. other (specify):	1,790,000	1,790,000
24. Total Long-Term Assets	5,041,415	5,074,751
25. Total Assets	5,336,379	5,369,715
CURRENT LIABILITIES		
26. Accounts Payable	228,853	228,853
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	89,825	89,825
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	31,200	31,200
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	367,015	367,015
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	716,893	716,893
LONG TERM LIABILITES		
39. Long-Term Notes Payable	32,158	32,158
40. Mortgage Payable	3,090,129	3,090,129
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	3,122,287	3,122,287
46. Total Liabilities	3,839,180	3,839,180
47. Total Equity	1,497,199	1,530,535
48. Total Liabilities and Equity	5,336,379	5,369,715

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,441,935
2. Discounts and Allowances for all Levels	6,948
Subtotal - Inpatient Care	3,448,883
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	92,000
7. Oxygen	0
Subtotal - Ancillary Revenue	92,000
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,002
15. Telephone, Television, and Radio	4,143
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	231
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	6,376
24. Contributions	0
25. Interest and Other Investments Income	1,658
Subtotal - Non-Operating Revenue	1,658
27. Other Revenue (specify):	17,649
28. Other Revenue (specify):	0
Subtotal - Other Revenue	17,649
30. Total Revenue	3,566,566
31. General Services	717,516
32. Health Care	1,617,705
33. General Administration	708,972
34. Ownership	376,465
35. Special Cost Centers	45,352
35. Provider Participation Fee	57,488
37. Other	0
40. Total Expenses	3,523,498
41. Income Before Income Taxes	43,068
42. Income Taxes	0
43. Net Income or Loss for the Year	43,068

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23 Provider Participation fee is linked from page 4